

The Physician's Role in a Hospital's Patient Education Program

■ Why involve physicians? is the question most frequently asked about the patient education program at St. Mary's Hospital and Medical Center in San Francisco. St. Mary's is a Catholic-sponsored community teaching hospital with 555 beds, an attending staff of 600 physicians, and a house staff of 93 persons. Approximately 90 percent of the hospitalized patients are private patients; 10 percent are patients without private physicians who receive their medical care through the hospital's outpatient clinics. Although St. Mary's has an outpatient department with 33 specialty clinics and approximately 34,000 patient visits per year, it was decided that the hospital's program, started in January 1973, would begin with inpatients. Therefore a significant proportion of the large attending staff and the house officers, many of whom change annually, need to be familiar with the program.

The patient education system at St. Mary's is defined as a planned educational experience, tailored to each patient's specific needs and lifestyle, and structured so that each participating health professional has a well-defined role within the team. Thus, relevance, consistency, and continuity of instruction are achieved.

Patient education is considered part of the medical regimen. It starts with an order, written by the patient's physician, for patient education. Then a multidisciplinary team (nurses, dietitians, pharmacists, social workers, and pastoral care counselors) assesses and shares information about the patient. The team designs an educational plan for the patient and carries it out with one-to-one teaching by its individual members. Followup needs are determined and this, as well as all other information, is shared with the physician.

The physician, who receives copies of the teaching team's assessment and educational plan for the patient, can suggest changes. For example, the physician may ask that we stress the importance of reading labels on medications with a specific patient or that we remind the patient of the importance of keeping regular medical appointments. When the physician receives copies of each lesson taught by team members, teaching can be reinforced and outcome improved.

The initial contact and the primary responsibility for the patient's care is the physician's. The physician makes the diagnosis that determines the therapeutic regimen to help the patient move from discomfort or disease to comfort or health.

The patient and the other health professionals share the goal of health maintenance, once the crisis which caused the hospitalization is over. Often, patients with chronic conditions need to change many daily activities as well as receive increased family support to prevent debilitation, and the patient must participate actively in bringing about the changes. The team must focus on the specific changes that must be made in the patient's lifestyle so that the medical regimen can be followed. The physician thus receives support from the team of health professionals as they address these changes with the patient, and he or she may gain a new perspective and new information about the



Physician reviews order sheet with staff nurse. In the St. Mary's Hospital program, patient education is considered part of the medical regimen.

patient, which can result in a more effective physician-patient relationship.

The team is concerned with the patient's lifestyle, fears and anxieties, family structure, and attitudes and knowledge about his or her disease or condition. Team members gain information about these factors in interviews with the patient and then share this information with colleagues. When they gather in a 20-minute team meeting to discuss the patient, they listen to each other, and a synthesis, which might be compared to a kaleidoscope, emerges. Each has seen one aspect of the patient, and the aspect changes with the differing perspective of each team member. As a consequence of this interaction, the patient can be viewed as a whole person and better understood by the whole team.

The following case histories illustrate how, through a kaleidoscope of perceptions, staff and physicians learn from each other and work together to help the patient adjust.

Three Case Histories

Case 1. Male, age 21; onset of diabetes, age 13
Physical handicap: left eye prosthesis
Primary diagnosis: diabetes

The patient was hostile; he had used drugs heavily, had had a run-in with the police, lost an eye in an accident at age 13, and had serious psychological problems.

The ward nurse developed a closer relationship with him after she discovered, and was able to allay, fears of impending oral surgery. The pharmacist learned that the patient was using various over-the-counter medications which conflicted with his insulin doses and offered to draw up a list of suitable over-the-counter medications which he could safely use. The psychiatric nurse consultant discovered that the patient strongly resented his diabetes and felt that his parents were indifferent to it. The dietitian learned that he always ate his meals in Italian restaurants with his friends and helped him select foods from a typical Italian menu.

At the team's second meeting concerning the patient, the physician learned of the patient's habitual midnight snacks with his friends. The physician then changed the time for the patient's urine testing, substituted a late-night for an afternoon snack, and changed the kind of insulin to be used.

In this case, each team member's information about the patient helped broaden understanding of the patient's fears and style of living. The physician was able to modify the regimen for that patient, so that adherence to it became a viable option.

Case 2. Male, age 59, newly diagnosed diabetic
Reason for admission: prostatectomy and vasectomy, abdominal mass

The patient was divorced, lacked family contact, was a loner, and claimed to have no friends. He worked from 7 am to 7 pm, lived in a rundown hotel, and usually spent evenings watching TV and drinking beer. He had a history of mental illness.

The dietitian stated that he had been eating many sweets, ate most of his meals at hamburger restaurants and that, although he gave lipservice to his dietary regimen, he was not likely to follow instructions.

Because of his short attention span, he was given instructions on recognizing early symptoms of hyperglycemia and hypoglycemia and the appropriate action to take. The dietitian helped him to modify his diet without changing it too abruptly. She suggested adding fruits and artificial sweeteners to his milkshakes, and showed him how to order well-balanced meals from the menus typical of the hamburger restaurants he frequented.

Three weeks after discharge, the patient visited the nurse and the dietitian to show them how well he looked, to assure them he was following their instructions, and to tell them that he had cut down on his beer drinking. The physician reported that his understanding of diabetes had improved. The staff's obvious concern about his well-being was amply demonstrated to the patient, and it served as the pivotal force in motivating him to change his food habits.

Case 3. Female, age 47, newly diagnosed diabetic
Reason for hospitalization: extreme weight loss, chronic alcoholism

X-rays of the patient showed pancreatic calcification. She lived alone in a three-room apartment, seemed alienated from her three grown daughters, and approximately 2 years earlier, her husband had committed suicide. The team wrestled with how to motivate the patient to become more active. The team felt that the patient required more socialization after discharge.

The dietitian discussed alcoholism with her and learned that most of the patient's friends drank in local clubs. The dietitian suggested that the patient inform the bartender of her diabetes and order nonalcoholic beverages.

Before her hospital discharge, team members congratulated her for having learned so much about her diabetes and encouraged her to stay active at home. The patient mentioned that, on her home pass, she had been surprised that neighbors showed concern, missed her, and asked questions about her illness. She had not realized that these people cared about her. As a token of her successful "graduation," a cookbook, wallet, ID card, and a basket of flowers were presented to her by staff members before she was discharged from the hospital.

This woman's case demonstrates the flexibility of the program. The patient was hospitalized in a psychiatric/medical unit for more than a month. Because she was receiving therapy for her emotional problems, the information was shared with members of the team focusing on her diabetes. She established rapport first with the dietitian, and it was to the dietitian that she first mentioned that she was alcoholic. Following discharge, she called the dietitian to ask questions about her diet and to tell her she had not been drinking. Six months later, we are informed that she is still "on the wagon." Her relationship with her physician also improved.

Setting Up the System

So that physicians, who have the primary responsibility for their patients, would be part of the teaching-learning process and have confidence in what we would be teaching their patients, they have been part of the patient education program from its beginning. The chief of staff, chiefs of medical departments, administrators, and directors of nursing, pharmacy, and dietary departments attended the first meeting to discuss whether a physician-prescribed system for patient education should be attempted at St. Mary's Hospital. Reservations were expressed, questions asked, and an approach was recommended and followed.

After the proposal was developed and submitted to hospital committees for comments, changes, and approval, it was submitted to the California Regional Medical Program and approved. First established was a medical advisory committee of physicians, a dentist, and a podiatrist selected not only for their interest in patient education but also for their influence within the hospital's community. The committee's 15 members were invited to participate by the project's medical director. Several physicians were unable to attend meetings, but correspondence with them brought good feedback.

One of the first tasks of the medical advisory committee was to set the educational parameters of the program. This task was achieved by several methods. Using a questionnaire, we ascertained from committee members what their patients were currently being taught about the specific disease, how information was transmitted to the patient, and asked them to cite specific problems that could be handled by educating the patient. Once we had tested the questionnaire we simplified it further—concentrating on two questions which were asked in a letter sent to the 600 attending staff members. From their responses we developed a physician order sheet. The order sheet, which has been revised five or six times, lists the kinds of things physicians wanted their patients to know and do by the time they are discharged.

The physician order sheet served as a basis for the teaching outline. The allied health advisory committee used the topics listed by the physicians to write educational objectives and spell out the specific instructions. The committee included nurses, patients, dietitians, pharmacists, social workers, community agency representatives, the director of volunteers, and representatives from the hospital's pastoral care department. All of the products of the committee's work were reviewed by the medical advisory committee for medical accuracy and then converted into lesson plans. At this point the patient education system was ready to be implemented.

Currently, the staff responsible for the operation of this system consists of a part-time medical director who is also medical director of the clinic, a full-time patient education coordinator, an administrative assistant, and a part-time secretary.

Evaluation

Of the first 100 patients referred to the program, 51 percent had a primary diagnosis of diabetes mellitus; 30 percent of these cases had been newly diagnosed. This proportion is in sharp contrast to the overall inpatient load; only 16 percent of the hospital's patients have diabetes mellitus listed as the primary diagnosis and the difference may reflect the physicians' criteria for referral. Eighty-five of the 100 were referred by private physicians, and the balance were patients referred by house staff.

In reviewing the data available on patients not referred to the program, we found that good control of diabetes, surgery during hospitalization, severe neurological or emotional problems (or both), cancer, and other serious conditions such as myocardial infarction or cerebrovascular accident were the main reasons given for the nonreferral.

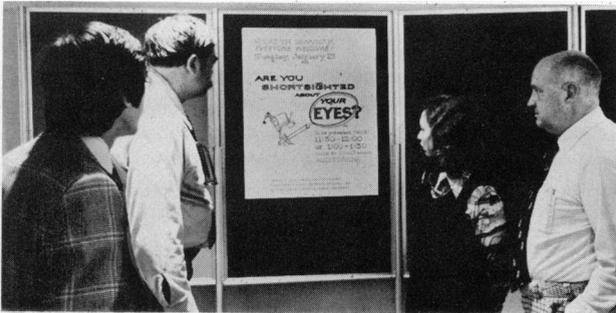
Two months after each patient was discharged, followup questionnaires were done with the physician and, by tele-

phone, with the patient. For those patients for whom followup information is complete, we found that 69 percent have had a desired weight change, 6 percent have maintained an acceptable weight, 87 percent have had lowered blood sugar, 9 percent have had increased blood sugars, and 4 percent have had no change. In short, we have helped patients change their eating habits, establish a daily exercise regimen, and learn more about diabetes in general.

Although this approach for diabetics is being adapted for patients with other disease entities in the clinic as well as the hospital, we have many other avenues to explore. We believe that the basic concept of a physician-prescribed, tailor-made patient education program is sound. It takes into account the importance of physician involvement and the wide variations among patients in their knowledge, attitudes, and lifestyles. Active participation by physicians in the planning and growth of the program has given our program strength and breadth, and it has contributed immeasurably to its success.

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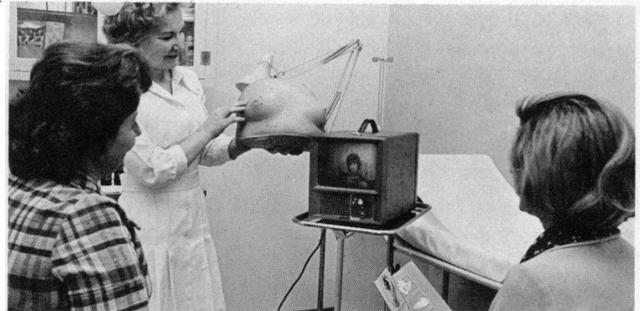
INDUSTRIAL HEALTH EDUCATION IN MORRISTOWN, N.J.



■ Attendance was high at a series of industrial health education programs offered to employees of the Bell Laboratories in Morristown, N.J., in the fall of 1974. Designed and carried out by the Department of Community Health Education of the Morristown Memorial Hospital, this series sought to reach people who ordinarily do not have the time or opportunity to participate in preventive programs because of full-time employment.

The series began with a program entitled "Living in Our Competitive World," in which the emphasis was on the psychological aspects of stress and how to deal with them. Subsequent programs focused on cardiac risk factors, cancer, dentistry, breast self-examination, and adolescent health.

The general objectives for this health education effort were to give employees medically accurate information, encourage them to seek regular medical care, teach them to recognize the early warning signs of health problems, convince them to change their health behavior with a view to improving their health and reducing the risk of illness,



provide onsite learning opportunities in such special areas of prevention as breast self-examination, and inform the workers of health education programs and health care services available in their community.

Each program in the series consisted of a 20-minute presentation on a specific health subject by an expert, followed by a 10-minute period of questions and answers. Whenever possible, high-quality slides or short films were included in the presentations. At each program, reading material was available for the employees to take with them—material that it was hoped would reinforce the health teaching, extend the program's influence to the families of program participants, and help advertise the series.

Each of the six half-hour programs was offered twice during the lunch period of a specified day (at 11:30 am and 1:00 pm). All programs were held in the company's auditorium, which seats 300 people. To attend a session, the employees had to walk a considerable distance and give up part of their lunch period.